

**CERTIFICATE OF EXCESS INSURANCE**  
**STATE OF KANSAS**

TO: DIVISION OF WORKERS COMPENSATION  
DEPARTMENT OF HUMAN RESOURCES  
800 SW JACKSON STE 600  
TOPEKA KS 66612-1227

DATE: \_\_\_\_\_

This certifies that a Workers Compensation Excess Insurance Policy has been issued and delivered to the employer named below, and that by issuance and delivery of said policy and the filing of this certificate of insurance, it is admitted that said excess policy was effective on the date stated below and that the coverage provided therein is applicable to benefits under the Workers Compensation Act of the state of Kansas and that said policy shall remain in full force and effect until 20 days after receipt by the Division of Workers Compensation of notice of its cancellation or expiration and/or non-renewal.

Name of Employer Insured \_\_\_\_\_

Address \_\_\_\_\_

Name of Insurer \_\_\_\_\_

Address \_\_\_\_\_

Policy Number \_\_\_\_\_ Effective Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

**FORM OF COVERAGE**

\*Specific Excess

Policy Limit \$ \_\_\_\_\_  
(Per occurrence)

Specific Retention \$ \_\_\_\_\_  
(Per occurrence)

Policy Term \_\_\_\_\_

\*Aggregate Excess

Policy Limit \$ \_\_\_\_\_

Loss Fund Percentage \_\_\_\_\_

Minimum Loss Fund \$ \_\_\_\_\_

Estimated Loss Fund \$ \_\_\_\_\_

Policy Term \_\_\_\_\_

If more than one insurer is providing coverage, you must provide separate certificates for each insurer.

**\*No changes shall be made to the Self-insured Specific Retention Amount or other limits of the policy upon renewal until approval is granted by the Division of Workers Compensation.**

\_\_\_\_\_  
Insurer

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Address